

Shrink Rap Radio, Episode #535, Maximizing Effectiveness in Dynamic Psychotherapy
David Van Nuys, Ph.D., aka “Dr. Dave” interviews Patricia Coughlin, Ph.D.
(transcribed from www.ShrinkRapRadio.com by Michael Wood)

Dr. Dave: On today’s show, I’ll be speaking with Patricia Coughlin, PhD who trains and practices Intensive Short Term Dynamic Psychotherapy. We’ll be discussing her 2017 book *Maximizing Effectiveness in Dynamic Psychotherapy*. For more information about Dr. Patricia Coughlin please see our show notes at shrinkrap.com.

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Dr. Dave: Patricia Coughlin welcome to Shrink Rap Radio!

Dr. Coughlin: Thanks for having me!

Dr. Dave: Well, I’m really pleased to have you on the show, you have written such a fine book here, it’s such a fine book. It’s called *Maximizing Effectiveness in Dynamic Psychotherapy*, and of course you are of the tradition of, and I always block on the initials...

Dr. Coughlin: It’s a little bit long, it is ISTDP, “...”

Dr. Dave: Right, right, and as you know I have had several other guests on this topic, and it’s great to have you take us even further today. Because I know this book is really a synthesis of a lot of years of experience, a lot of thought and a lot of training that you’ve done, not only of yourself but of other people.

Dr. Coughlin: Yeah, absolutely, so, it’s interesting when you say, of course, I’m known for ISTDP, but my training and my orientation started out as a very traditional, psychoanalytic, psychodynamic one which I think gave me the advantage of having such a wonderful theoretical base.

Dr. Dave: Yes.

Dr. Coughlin: But I started to get frustrated after seven or eight years of traditional practice, just knowing that I wasn’t able to be as effective as I could be. And when I discovered ISTDP, Dr. Davenloo’s work, it was like a duck to water. Finally I had some of the tools to really work with the dynamic unconscious and get much more consistent results, deeper results more quickly. And I’ve written two books about ISTDP.

Dr. Dave: Your other books, yeah.

Dr. Coughlin: Yeah. And this book, in a way, I very intentionally did not have ISTDP in the title. Back to dynamic psychotherapy to again really integrate theory and technique and to get ISTDP a bit more in the center of the discussion because I think many still don’t know about it.

Dr. Dave: Yeah, and interestingly you say that you felt that before you got into IST...

Dr. Coughlin: ISTDP!

Dr. Dave: I've made a note to myself; I don't know why I keep scrambling those initials! But you said that before you got into that, you didn't feel fully effective. And so you actually, in this latest book, you cite some studies that indicate that maybe 50% of therapists are not operating at the highest level of competence that would be available to them. What can you tell us about that?

Dr. Coughlin: Yeah, that's for sure! It's interesting that that bell shaped curve just keeps popping up all over the place. And so therapists, just like physicians, attorneys, teachers seem to fall along this bell shaped curve. So most of the people are somewhere in the middle. Then you have the 20% of therapists on the left side who do better and more consistently effective work than the rest. You also have some people on the right side of that bell shaped curve who actually do damage and you should definitely stay away from. So the issue is that, let's say if you have an average problem, you know, you've a depression subsequent to a break-up, or you have some anxiety about getting into medical school or something, one of those average therapists is probably going to be able help you. But it's the people who have complex disorders of longer standing and it looks like about 80% of our patients actually fall into that category. They have tried lots of treatments and they haven't gotten a lot of help. And those are the people who really need one of those super shrinks, one of the people who have a proven track record of being a little more effective than average.

Dr. Dave: Well, say a little bit more about the research that that estimate of only 50% performing at or beyond the median, let's say, or maybe even higher, I don't know how big that slice is, is that based on a self-report, or a mix of self-report and some more objective measures do you recall?

Dr. Coughlin: Well, that's a good question. Really, it's based on the increasing call for evidence based [practice] and for people actually gathering data both on symptom changes using the SCL90 for example, but also on interpersonal problems, how people are actually functioning using the GAF scale. So this is really looking at the relationship therapist activity right, their interventions, and the outcomes they are able to achieve. Now again, the bad news is that our traditional ways of training therapists, believe it or not, there's no evidence that there's a relationship between that traditional method of teaching and supervising and outcomes. Right! So we keep doing the same thing, even though there's no evidence it's particularly effective. So...

Dr. Dave: But you're doing training that you believe is effective.

Dr. Coughlin: Right, and that we also are doing studies on. But there is evidence that in particular, using videotape is highly effective. We are actually seeing what's happening in the session, we're not just basing our supervisory comments on the therapist's report. The therapist can only report what they're aware of, first of all. So they might have missed all kinds of important things that we could see on the tape. If we don't see it, we can't make use of it.

Dr. Dave: So in supervision, you review actual sessions and I assume with the therapist and yourself or a group of supervisees and you stop the tape periodically to say, “okay, what was going on in your mind at that point?” and “here is what I suggest.”

Dr. Coughlin: That’s right, and also pointing out that we tend to listen a lot to the content and yet the unconscious speaks non-verbally in the body. And so if a therapist just reported a particular interaction, but I’m not getting the tone, I’m not seeing that the patient is actually looking down at the floor and completely avoiding eye contact with the therapist, then that’s a very different picture than if I actually see the person is sitting forward, looking at them, they have some energy in their voice. So, it’s all these kinds of things that are so crucial to effective psychotherapy. It’s not just the words, it’s the music.

Dr. Dave: Yeah. Now, there have been something called the common factors, Right? Of what should be taking place in good psychotherapy. People being empathic and good listeners, take us through those, you say they are not enough, but let’s start with those.

Dr. Coughlin: Well, not only are they not enough but, Joel Weinberger wrote a wonderful article back in 1995 that I don’t think enough people know about. It’s called “Common Factors Aren’t So Common.” First of all, we talk about these factors [such as], of course, the relationship factor, right? Having that empathy and connection. What one of them, and we often think that is so crucial, and what he found out and many others have too, is that developing a good collaborative relationship is absolutely essential but also insufficient for change. So if that’s all you’re banking on, you might have a nice connection, the patient might enjoy coming to talk to you, but it’s not that likely they’re actually going to get deep and enduring change. Though you need some other things, including, and the most potent one that he found, was helping the patient confront what he has been avoiding, in whatever way you do that. And then subsequent to that, is establishing the fact that the patient now has a sense of mastery and competence. So where they may have come in feeling anxious, unsure of themselves, having now confronted what they had avoided and being able then to resolve the issue, of course, their competence and sense of mastery is increased. On top of that, it’s really vital that the patient attribute the change to their own efforts.

Dr. Dave: That sounds like you’re going beyond the common factors that he talked about.

Dr. Coughlin: Well he was saying, he went through, so Weinberger did this big meta-analysis, and he actually said that all of those have been considered common factors, and yet that was his whole thesis, that the common factors were not so common!

Dr. Dave: Ah, so that they are not being used.

Dr. Coughlin: When it comes to that, we tend not to teach and learn and institute these multiple factors. Most therapies will just focus on one or two of them to the exclusion of the others. And this is why I think also Bruce Wampold and Bruce Ecker are talking about the common neglect of some these vital factors as being responsible for the fact that we have not improved as a profession in the last 50 years. Despite this proliferation of therapies over a thousand different kinds now, all of the different diagnostic categories we come up with, but when it comes to that

skill and craft of psychotherapy and how to help a specific person with specific problems, we still have a long way to go, and it's really stagnated.

Dr. Dave: Yeah, I've been hearing that elsewhere from a couple of other guests, and it's a little shocking to hear each time that I hear it, but I don't doubt that it's true. And one of the things that you talk about is the importance of the person, the person's personhood, if you will. And I always thought "well, I'm a good person, and that's just going to be healing in itself." But it's not enough!

Dr. Coughlin: Right!

Dr. Dave: You say there needs to be more than that and I could be deluded in thinking of that about myself. So what else is needed beyond those personal characteristics?

Dr. Coughlin: Yeah, so and what are those personal characteristics, first of all? So, one of the points I'm really making in this new book is that it is both who we are and what we do that matters. And having those somehow integrated. We tend to have these polarities in our field. You know, it goes from all this focus on empirically validated techniques, right? And then when it doesn't pan out it's, oh, no, it's not that it's just some therapists are better than others. But again, I don't think these simple either-or's tend to work over time. So, some of the personal characteristics of the best therapists are not just that their empathic and understanding, of course that's essential, but they also are lifelong learners. The best therapists are just never done. Their open, their learning, their open also to the patient's feedback, and they're really hard working. So the best therapists tend to spend seven times as much time as their average colleague. That's significant right? Reading, thinking about, reviewing cases, looking at their tapes, getting supervision, going to seminars. So there is no shortcut to mastery in such a complex profession as we have. The other thing about the best therapists is that they are masters interpersonally and a big part of that is that they seem to be able to deal with "difficult patients." Hostile and resistant patients for example, without themselves getting triggered or, being themselves, defensive. They actually tend to encourage the expression of negative affect instead of trying to talk somebody out of this trying to present yourself as this nice understanding person. You know, you'd say "well, you seem really angry, right off the bat there's kind of antagonistic tone here, are you aware of that? Yeah." "So you have a lot of anger already, coming in, can we look at that?" They're not put off by it, they actually encourage it. So there are a lot of very sophisticated skills and personal characteristics of courage and determination, so that even if you teach somebody these skills in a training seminar, will they be able to use them under fire?

Dr. Dave: Uh huh, that takes a lot of practice, right? A lot of practice a lot of feedback.

Dr. Coughlin: It does, and that commitment I think to our own personal development, our ability to be able to, as I say to my students often, we need to get over ourselves about you and can you really be willing to devote yourself to the care and wellbeing of this other person even when they are very difficult.

Dr. Dave: So, beyond those common factors that we were talking about earlier, you make a case for very specific factors which you've been getting as being vital for effective therapy. And you

list six specific factors. And I'd like to read through them and then we'll step through them one at a time and I would like to encourage you to expound on each one with whatever comes to mind to expand it and to give any source of concrete examples that might come to mind because your book is loaded with solid examples and case examples. So to go through the six, the first one is maintain a high level of focus, the second is develop an atmosphere of trust, by displaying skill and competence and being a resource for patients and students. Build a collaborative alliance in which both participants give 100% of their effort to the task, I think you have been foreshadowing this in what you've been saying already. Number three is facilitate intense involvement in which multiple modes of experience, cognitive, emotional, physical and interpersonal are facilitated and integrated. Number four is keep anxiety and stress in the moderate range, that's an interesting one, alternating with periods of calm consolidation. Number five is encourage profound moments of meeting by encouraging removal of barriers to intimacy and closeness. And then finally, number six, develop meaning and a coherent life narrative. So, let's start with number one, maintaining a high level of focus. What is that about?

Dr. Coughlin: Yes, indeed, I'm happy to get into that. Now, before I do, I just want to say that these six factors, it's not something I came up with, and it's not just my opinion. So both process research, not RCTs where we're just comparing CBT and ISTDP, but we're really looking at what are you actually doing, not what you call it but what are you doing. So this process research and then also some new brain neuroscientific research, they seem to agree that these six factors are required to change an adult brain and to actually get deep and lasting therapeutic change as the result of therapeutic intervention.

Dr. Dave: I just want to underscore one thing here, which is your commitment to empirical research and your strong belief that even though you kind of did quotes around evidence based, that despite whatever criticisms there are of that, you're still a strong believer that our work has to be supported empirically.

Dr. Coughlin: That's right and the difference again being not talking about empirical validation for an entire model like CBT or ISTDP, because when we do that, all these RCTs always come out with the same result which is that all the therapies are helpful but none more than another.

Dr. Dave: But what are those initials you're using RCTs?

Dr. Coughlin: Oh, sorry, randomized clinical trials where they're comparing large groups, one being treated for example with CBT and the other with ISTDP. So, you're comparing groups and you're comparing models. Again, what somebody calls what they're doing. And when we do that, and we've been doing those for 50 years, spending a lot of time and money, and getting the same results over and over again. What happens is all the variation goes out in the wash. So, within group variation is greater than between group. So, it doesn't matter what you call what you do, what matters what you actually do. That's where process research comes in. We can actually look at what is the effect of having a focus, right? That was our first topic here. What effect does that have on outcome? And it is actually quite significant. So therapists who take some charge of the sessions actively focusing the patient on their areas of difficulty on the symptom generating situations and in particular what we would call an internal focus. All too often, therapists sit and listen to patients talk about other people, blaming about the boss or their

kids or their husband. This doesn't help anybody. So how can we say "I understand that it sounds like your husband has some difficulties with drinking, but my real concern, I mean you're the one here to see me, is what are the difficulties you're having in dealing with that?" So how we create and then maintain this internal focus and getting agreement on what we are actually here to address has a very significant relationship to outcome. Conversely, those therapies that are unfocused, where people kind of shoot from the hip and go with the flow and so on, actually are associated with negative outcome. So focus on both levels, the more you sustain an agreed upon focus the better your outcome is likely to be, and a failure to focus will set you up for failure.

Dr. Dave: And when you talk about the internal focus, are you talking about, not just about the therapist has to stay on point within themselves, but also you're hoping that the client will begin to adapt a similar concern.

Dr. Coughlin: Yeah, and it's not really in a way about hope, but it really is about unless and until the patient sitting in your office can identify a problem that they are having internally, their own conflict, you really can't do therapy. You can't do psychotherapy. You can give advice, you can do problem solving but psychotherapy is a therapy of the psyche, of the internal world of the patient. How whatever their life circumstances are is actually affecting them internally. What's that stirring up that they are struggling with. In a way, unless you develop this agreement that you're there to help this patient with their internal problem, then you as the therapist are in somewhat of a helpless position. There's nothing you can really do about the patient's boss or these external things, so it helps both the patient and the therapist to get clear about the internal nature of the problems to be addressed.

Dr. Dave: Yeah, I am thinking of the patient who comes in expecting a magic bullet, and they're not really owning the issues themselves. They're not really struggling. They're "okay, I'm giving this to you, you're the expert, tell me what to do."

Dr. Coughlin: That's right, that's a great example, so as long as that patient is using the defenses of externalization and also taking a helpless position, looking at you as omnipotent, those defenses are going to interfere with the development of the kind of collaborative relationship required to do psychotherapy. So therapists have to make sure they don't fall into that trap, right? Where they somehow think somehow they think they're the ones that are going to cure this patient. As I often say, I've never cured anybody, but I do help facilitate a healing process in which that the cure takes place internally.

Dr. Dave: Yeah, great, let's move on to your second specific skill, I guess, develop an atmosphere of trust by displaying skill and competence and being a resource for patients and students, build a collaborative alliance, that's kind of what we were just getting at, in which both participants give 100 percent of their effort the task.

Dr. Coughlin: That's right! Again, so these things do sort of flow, we can just see that even in our conversation, that even getting that agreement on the focus requires that the two of you are collaborating, you're working together to try to understand the underlying nature of the symptoms the patient is complaining about. You want to be getting an agreement then about what the goals are so that you can also agree about then what is the task? So given that this A is

the problem and you want to be over here, this is your goal, then what do we have to do to get from here to there? So again, developing this collaborative alliance is much more than just having an emotional bond which is what many people think of when we talk about a therapeutic alliance. Again, just liking a therapist or seeing them as sympathetic is not enough. So, getting this agreement on the problem, the goal and the task is an essential part of that collaboration and as you're doing that, you're displaying your skill and your competence and you are also inviting the patient to become actively involved. And in a way, this is really what I call, the reality principle, if the patient is sitting there passively, not really involved waiting for you to come up, how likely is that to happen? So that is just the reality. If they're not feeling, so this is where we actually ask, and I think therapists often don't ask their patients for anything. You know it's this one way street. I will ask for their willingness, I ask are they willing to be open, right, and to see what we can do together. Are they willing to give 100 percent of their effort along with me so we can see what we can really do here? So that is absolutely really essential.

Dr. Dave: And your number three competence, you kind of turn the knob a little bit further to facilitate intense involvement in which multiple modes of experience, cognitive, emotional, physical and interpersonal, are facilitated and integrated.

Dr. Coughlin: That's right. So this is really all that we've known since, you know, Frank long ago, Alexander and French, you know, decades and decades ago, that an intellectual kind of therapy, whether it is psychoanalysis or CBT, is not likely to reach a lot of people in a deep transformational way. We have to create an emotionally activated environment. But how do you do that? So unless you know how to really keep your eye on emotion, to ask the patient how they're feeling as you begin to get into different areas, even focusing them on their own difficulties, not allowing them to just talk on and on about others, you might see a rise of emotion. They might suddenly start to cry or to seem angry or annoyed with you for interrupting them. So again, we would invite this experience of emotion which is so crucial to getting to the unconscious origin of the patient's problems. And I'm talking about the multi-levels of emotional experiencing. So this has become very popular now these days. There's this general understanding that emotional awareness and regulation is absolutely key, you know, even in CBT, the third wave they say, "oh yes, we're talking about emotions." So they might focus on the cognitive labeling of emotions. Emotion focused therapy might focus on the actual experience in the body of that. Somatic experiencing talks about the physiological activation, and what the body wants to do when angry or sad, right? And then we're also talking about how to interpersonally communicate those emotions. So the more you can access and then integrate multiple levels of emotional experiencing, not just cognitive, not just physical, but all of them, it's much more likely that the patient not only is getting deeply involved in the therapy, but it looks like that deep visceral experience of the previously avoided emotion is actually the trigger that tends to unlock the unconscious memories and sources of the conflicts and problems that the patient is coming in with. So it's really a very rapid and reliable root to getting to the bottom of it. Getting to the engine of the patient's symptoms and suffering.

Dr. Dave: You say very rapid and that brings us back to the name of this approach of being short term. So this is what tends to speed it up, is keeping this level of emotional focus and you early on emphasized that some of this is based on research on the brain; and for long lasting and significant change, that these emotional levels have to be involved. And this leads into the fourth

competency here, which says keep anxiety and stress in the moderate range, alternating periods of calm consolidation. So in other words, you don't want them to be too relaxed.

Dr. Coughlin: That's right! So this is something that, and maybe these two, both the emotional activation we were just talking about and this issue of being able to keep the patient a little uncomfortable, right? Where they are actually anxious, you're approaching those hot button topics, I mean that's what we are there to do. So if you keep avoiding that, if you keep anxiety too low, no change really happens. So it is a bit like Goldilocks, if there is not enough anxiety, nothing will happen. If the anxiety is so high that the patient is starting to get dizzy or disassociate, obviously, you don't have a patient to work with and that's not going to be helpful. So really watching, because this is going to be different for each patient and even with them different from session to session, that you're watching for what we call, signals of anxiety to make sure that anxiety is in that optimal zone and not too high. So we do want that person to be a little uncomfortable and approaching the very things they tend avoid so we can help them deal with it and resolve it some constructive manner.

Dr. Dave: I wonder if this is challenging for some therapists, to be able to turn up the level of anxiety, and maybe if maybe it is just not in their personal style, or maybe they have needs to be liked, and so it's threatening to move into that. So what's your experience there?

Dr. Coughlin: Yes, I think those are really good comments and this is where I feel we have a responsibility as therapists to push ourselves and to get over ourselves. It's not about me being comfortable, right? So I have to be able to tolerate some of my own anxiety in order to confront what needs confronting. Sometimes very much directly between the two of us, if there's been some kind of acting out for example in the treatment with people canceling, not paying, whatever. It might be anxiety provoking to bring it up directly and yet that is our job. That is our task and this is where ongoing training and supervision is so important because if you as the therapist is uncomfortable, how are you going to help the patient to deal with their discomfort. And this is another thing that I repeat, I think in the book as well as my trainings, which is that we have to be willing to practice what we preach. And if we are not able to tolerate anxiety for growth how can we with any integrity encourage our patients do the same. And believe me, our patients are keeping an eye on us all the time and they're reading us and they can read whether we're anxious or not. Whether we really mean what we say and are willing to have an honest look at what's going on with them; willing to face these very difficult feelings that they might have, including towards us, the things that come up. So they're going to test us out and this is why our own personal work, dealing with our own anxieties, our own conflictual feelings, being willing to put down our own defenses is absolutely essential to effective psychotherapy.

Dr. Dave: Yeah, this raises an interesting question of, I think there are a lot doctoral programs out there that don't require the therapists that they're training be in therapy. What are your thoughts about that?

Dr. Coughlin: Well, this is certainly my personal opinion, I'm troubled by that and I think that as the field got more and more cognitive over the last several decades, you know, they just thought it wasn't important, you're just dealing with the conscious rational thoughts that people are having. But, to do any kind of depth oriented work, emotional work, again, I think it's our

responsibility to make sure that we're a relatively open, uncontaminated space. So it's something, in our country, I don't think we can demand these things, but certainly, in my experience, most therapists who want to do this kind of work just go voluntarily. I mean, you don't even have to ask them. Other times, in supervision, if the trainee isn't learning and you're having to repeat that there's some kind of emotional block or that their anxiety is so high that they can't really process the feedback, then they really are going to need to get some help themselves in order to be able to clear that up, and again, be that space where they can be truly available to their patients and not getting triggered so quickly themselves. You know, because we are the vehicle of transmission of the therapy itself, and so as such, we can't really remove ourselves from the environment, so it's who we are in our being as well what we do that really matters.

Dr. Dave: Sure. Okay, point number five is encourage profound moments of meeting by encouraging the removal of barriers to intimacy and closeness.

Dr. Coughlin: Yes, so again, it never ceases to amaze me how therapists, and of course this is what I get to see when I'm watching the video tapes, which I will not do supervision without anymore. I just feel I can't do a competent job without seeing what is happening there. And I will literally see videotapes where the patient comes in, they sit down, arms crossed, legs crossed, hat on, coat on, eyes to the floor and the therapist starts talking as if they have a patient in the room. So they're not addressing all of the barriers to the patient's presence and engagement. So when that is apparent, we must address it. "Are you aware that there is a way in which you're here but not here? I mean, physically you're present, hmm? But your eyes are to the floor, your coat is on, you're curled up, are you aware of that? You must be anxious about being here, can we look into that? And again, are you willing to connect here with me so we can try to understand what's going on." Without the patient's willingness to be open, present and engaged, it doesn't matter how many great skills you have, the patient isn't available to it. So these are the kinds of things that have to be addressed and the patient has to be willing to remove these walls, these barriers, if we are going to have that kind of engagement that's going to result in an outcome they're looking for.

Dr. Dave: Again, I think the challenge for the trainee therapist is to be confrontive to be able to get over whatever blocks they have against being confrontive and somehow not to being attacking. I mean, that is kind of a fine balance, you know how you are going to say it in a way that is not received as attacking. How do you do that?

Dr. Coughlin: That's right, your tone is really important. You know, so sometimes people will read my books and they read all these transcripts, they're actual transcripts and they're getting a certain image in their mind. Their reading it and they're thinking, "oh gosh, that sounds really confronting," like you say, and then they'll come to a work shop and they actually see that case that they just read and they go "oh my gosh! But it didn't feel confronting because you're tone was so different." So that is really important, that you have to make sure that you're not in fact attacking the patient because you're angry and impatient and whatever. I like to think of it more as an invitation and that it's also back to reality principle. So I might say "I would really like to help you, I can only do that if you're willing to open up here. I can't do it without your cooperation. So would you be willing to open up here with me to make a connection so that we

can see if we can work together?” And I find that people are very responsive to these “willing” questions. “Would you be willing to give it a try, would you be willing just to do an experiment, let’s see what it’s like, and I wonder what kinds of feelings come up, you must be anxious. And so when they realize, “oh yeah, when I look at you, wooh! My anxiety goes way up.” So that it’s understandable that when you shut down and withdraw, your anxiety goes down, well in a way that’s the good news but the bad news is you create a barrier here. You shut down and the very things you need help with you don’t raise, so, looks like that is a cost to it also. So that you’re then helping the patient really see that they’re in conflict, that what they’re wanting and how they’re engaging are not in alignment and what are they going to need to be able to do to get the outcome they’re hoping for.

Dr. Dave: Yeah, well the sixth point is develop meaning and a coherent life narrative, why is that important? If we’ve got the emotion, we’ve got the anxiety, we’ve got all these other elements...

Dr. Coughlin: Your right, and in a way they are all leading up to this final factor which is that it’s much more likely that you’re actually going to discover the unconscious origin of the patient’s symptoms and suffering if you create a highly focused, emotionally charged atmosphere in which the two of you are working closely together. You know, that eye contact is activating the whole unconscious attachment system. And so it’s much more likely that as you engage in that way, the patient’s unconscious will open. And, literally patients will say “oh my god, it’s so weird, it’s almost like I just had this flash in front of my eyes. I totally forgot this, but I just saw my grandfather standing...” and they have this memory when, literally, they made the decision that anger was dangerous and they must never feel it again. So, it’s a very rapid and reliable route to the derepression of these crucial memories that help us make sense of the origin of the patient’s conflicts. Once we do that and the unconscious is now conscious, the adult ego, right, the adult patient along with you, has the chance to reevaluate decisions that were made when the patient was three years old. And literally, I’ve had patients just look at me and say “this changes everything!” I mean, this is what we mean by transformational change. It’s rapid but deep and enduring. That there was deep unconscious belief that had been operating all these years and that once that becomes derepressed and has come to the light of day and the patient realizes “that’s is ridiculous.” As one of my patients said, “I sort of vaguely remember the way I used to be, I know I was incredibly masochistic, I just couldn’t do that again if you paid me a million dollars, I mean, it just couldn’t happen now.” So something changes very fundamentally in the patient’s sense of themselves. And because they are now able to remember the incidents that formed those initial conflicts those initial beliefs, many things that made no sense to them coming in, first of all, make sense now. Often patients will say “I don’t know why I do this. I mean, I know that washing my hands the 75th time actually couldn’t do anything, but I can’t help it.” They’re a mystery to themselves. And so as these memories are de-repressed following the experience of these anxiety provoking affects, they can suddenly understand that “oh my god! Now it all makes sense! Now I see it!” And then compassion for the self comes quite naturally, it’s not something you have to teach someone to do. They see what happened, they understand themselves. Often they will now understand others in a more nuanced three dimensional way. And so, when this happens, patients are no longer triggered. It’s literally been resolved at the source. So they don’t have to try to manage their anxiety or manage their OCD. The need for the symptom is gone, resolved. So that’s what we really mean by transformational change, which I think is always our

goal, not that we always get that result, but that kind of freedom where the patient no longer being triggered and having to manage symptoms.

Dr. Dave: Okay.

Dr. Coughlin: Let me just say one more thing about the coherent life narrative. We also know from all the attachment research that having a coherent life narrative is highly associated with secure functioning. So for a mother or father to be able to create a secure relationship with their children, they need to have their own coherent life narrative. So even though I treat individuals, what I end up seeing with this kind of work, which is again so gratifying, is that as they change in a deep and profound way, the nature of their relationships with others changes and they're able now to begin to create and maintain secure, healthy relationships with other people in their family and at work. So you do see this sort of outward spiral, just as one person can take others down, I've also seen one person in a family system really be able to be a healing force in their life.

Dr. Dave: How has doing this intense emotionally focused work impacted you?

Dr. Coughlin: It's a great question; it's had a profound impact on me. Certainly, I have expanded enormously in my capacity to tolerate all kinds of intense mixed feelings within myself and from others without getting anxious and without getting defensive and as I do that, of course, the depth of connection and the ability to have really deep, meaningful, intimate relationships has expanded. But I think there's another side to it. I know many therapists who started with this work and really did remarkable work. I saw it on videotape, the most profound healing and transformations with patients. And I saw over them years, give it up, and start to move away from it, and start to go back to sort of loose, maybe, sort of, empathic, supportive... And I'm thinking "what in the world is going on here?" But, I'm telling you, because I've been doing this for thirty years now, doing it myself, teaching it, supervising it. And while we get these wonderful outcomes, in order to get there, we often go to hell and back with patients and it takes a toll on us to be, especially because again we invite feelings very directly toward ourselves. The patients are fantasizing you know, beating me up, raping me, killing me, and so I have realized that, "okay, is there a therapeutic reason for that?" And we get through that and of course then the patient feels tremendous guilt and sorrow about it and then they connect to their love and of course that gets linked to unresolved things from the past. So there's all a good reason for it, but to be confronted with this day in and day out along with the traumas that have given rise to these intense reactive feelings towards others, I think we really are at risk of some secondary trauma. So unless we have support in our own lives, people that we can talk to. I remember this was only a few months ago, I was seeing a patient for the first time, and when I do that, I always schedule three hours. And this is something I learned from Dr. Davenloo and is really a vital part of ISTDP, the extended initial interview so that we really have the chance to actually do the work in that first meeting. It greatly accelerates the process. So this man came to see me, he had been suffering for twenty years, not only with anxiety, OCD symptoms, depression and every conceivable ache and pain and all kinds of unexplained medical symptoms. He had been every doctor in the area, he had gone through every possible test and he finally himself was convinced that there was no organic cause and that he knew that it was emotionally based and that he wanted to get to the bottom of it. So he did some research and found out that ISTDP is a

treatment that's effective with pain syndromes and unexplained medical symptoms. So he comes to see me and quite rapidly he was really open, very cooperative and highly motivated. And quickly it became apparent that his pain would flare up around issues where anger was getting activated but he suppressed it. It went quite quickly back to his father who was a really brutal sadistic kind of guy. So as we were talking about this and I was asking for some examples, and he remembered how his father would taunt him with things like him being a sissy and a patsy ass and things like this and he would dunk him in the swimming pool repeatedly, you know, wanting him to fight back, this kind of thing. So I would ask him how do you actually feel that anger inside, in the body, right because I want that activation. He said, "well, there's a little bit, not that much, you know, maybe 20% of what I know is there." So I'm like "okay, how are we going to get some more activation." So I ask him "alright, so if you think about the thing you are most angry with your father about, so we can really help you get in touch with this, what would you say that is?" And he pauses and he looks right at me and he says, "Well, I guess that would have to be that he murdered my mother and he killed himself and I'm the one who found them."

Dr. Dave: Oh, geez.

Dr. Coughlin: Oh my god David, I literally felt like, I can't even describe it. I mean, I was almost overwhelmed with man's inhumanity to man. You know, what people have to deal with. And, I held it together, I did my best and I think I was able to help him, but I tell you, I staggered out of my office that day and just knew I needed somebody to talk to. So I think that this is why a lot of us shy away from this because it is so difficult to deal with, and it's tempting to want to skim the surface or avoid these horrendous things, but this is what our patients are carrying around with them. You know? So I think it's affected me, as I say, in all these ways, I feel the joy more deeply and I feel the horrible pain and the horror. So I think it's very important when doing this kind of work the numbers of hours you do or the kinds of patients you see.

Dr. Dave: Yeah, I wanted to ask you about that. What would be your rule of thumb?

Dr. Coughlin: Definitely, people are different so you have to gauge for yourself. And it's different for me now than it was years ago, because I am doing a lot of teaching and supervision so I am probably only seeing patients two or three days a week. But you just have to keep in touch with yourself and know, are you working at your optimal level? Are you getting tired? Are you starting to detach? And what do you need to do to restore yourself? I took up tennis a couple of years ago; I paint, as well as having a rich network of friends and a good social life. I think these things are really important to keep our eye on.

Dr. Dave: Right, well you know, that could be a good close for the interview here, a good place to wrap it up. Or, maybe there is some other thing that you've want to say that you didn't get a chance to.

Dr. Coughlin: Yeah, I think the only other thing that I would like to say, is that exactly what we are doing, David, is a part of this. Being able to talk to each other about how difficult this work is as well as how rewarding it is. This is why I now do training groups that are very cohesive and they stay together for a number of years and I just find that people's learning is much deeper because we are supporting each other. It is a lonely profession, we are in there by ourselves so I

am just so appreciative that you are doing this kind of work where you're talking to therapists and also supporting us to be learning constantly. Which is the other way to feed ourselves and stay fresh is to listen to what other people are doing, read outside of your narrow model. We can always be learning from other people, other methods and so I think that's all really important and I'm just very grateful to you for the service you're providing to all of us.

Dr. Dave: Well, thank you I really appreciate your being so inspirational, I feel very inspired just talking to you. And I want to thank you for being my guest here on Shrink Rap Radio.

Dr. Coughlin: It's been a real pleasure, thanks so much David.